SOUTHWEST PSYCHOTHERAPY ASSOCIATES

Micki Grimland, **Owner**
Brandy Lerman, **MEd, LPC, CHt**
Ty David Lerman, **MA, LPC-S, CHt**
Jennifer Palermo, **MA, LPC**
Dianne Pulsipher, **MA, LPC**
Taylor Shaw, **LCSW**
Sue Steinbruecker, **LCSW, ACSW**

NEW PATIENT DATA

(Please Print Clearly)

Patient's Name:_____Age:_____Birthdate:_____
Gender:_____Marital Status:_____Education:_____
Address: _____City:_____State:_____Zip:_____
Home Telephone:_____Cell Phone Number:_____
Employer: _____Occupation: _____
Work Address (Adults Only):_____
City:_____State:____Zip:_____Work Telephone:_____
E-mail: _____
Referred By: _____
Reason for Referral: _____
Previous Mental Health Contacts or Evaluations: _____

Family Physician:_____Ph#_____
Approximate Date of Last Contact:_____Overall Health Status:_____
List Any Chronic Health Conditions: _____
Current Medications: _____
List ALL Members of your Family and their ages: _____

_____

I have read the schedule and the policy on payment of fees
Signature of Patient, or Legally Responsible Adult:_____
Health Insurance Company:_____
Group Number:_____Member Number:_____
Social Security Number:_____

2500 Wilcrest, Suite 401 • Houston, Texas • 77042
832-333-3030

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FEE SCHEDULE AND POLICY ON PAYMENT OF FEES

The hourly rate for therapy is $_____. Additional time will be charged accordingly. Phone calls, texts and email exchanges will be charged the hourly rate. The client is responsible for payment of all fees. Payment will be made at the end of each session. Insurance claims are to be processed for direct reimbursement by the client. Insurance ready billing forms will be available. If any account goes unpaid, a service charge 1.5% will be added. 18% APR will be added to all overdue accounts. The client will also be liable for all legal and collection fees.

A 24-hour notice will be given if a session has to be cancelled. If a 24-hour notice is not given, the session will be charged to the client's account.

Special arrangements are possible through written agreement by the client and the therapist.

_____ _____

Date Client Signature

_____

Therapist Signature

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CLIENT'S INFORMED CONSENT AND STATEMENT OF UNDERSTANDING

I have chosen to receive services by a Southwest Psychotherapy Associate. My choice has been voluntary, and I understand that I may terminate therapy at any time.

I understand that there is no guarantee that I will feel better. Because psychotherapy is a cooperative effort between my therapist and myself, I will work with my therapist in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

Limits of Confidentiality

I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information.

I understand that, in accordance with state and local laws, my therapist is required to report and will report all cases in which there exists a danger to self or others, and cases in which my therapist may suspect abuse or neglect of a person (child, elderly, developmentally disabled) who is presumed to be unable to protect self.

I understand that if I use my insurance benefits to help pay for my therapy, it will be necessary for my therapist to disclose to the insurance company my diagnosis and in some cases information which establishes the medical necessity for treatment. This information will become a part of permanent insurance record. Insurance claims will be filed directly by the client. This office does not file insurance claims. We will provide Insurance ready forms for you.

Emergencies

A therapist will be on call when my therapist is on vacation. My therapist's cell phone number is _____. The SWPA, PA answering service is 832-333-3030. The weekend coverage will be found at this number. I have written this number down.

I understand that answering services are not perfect communication devices. If I do not hear from my therapist or the therapist on call within a reasonable period of time, l will leave another message at the office number. In extreme emergencies, or if the phone system has failed, you may call your therapist's cell phone. (Be sure to obtain this number from your therapist.) _____ (insert therapists cell number.) If your therapist does not respond in a timely way, please call 911.

I have read and understand the above.

_____ _____

Signature of Client Date

_____ _____

Signature of Therapist Date

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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____authorize _____
(Name of Patient) (Name or Program which is to make disclosure)

_____to disclose to _____,
(Name of person or organization to which disclosure is to be made)

the following information_____, for the
(Nature of information)

purpose of_____.

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent shall expire 60 days after the date signed unless another date is specified.

Specification of the date, event or condition upon which consent expires.
_____

To the Party Receiving this Information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or is otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. FOR PATIENT RECORDS APPLICABLE UNDER FDERAL LAW 42 CFR Part 2.

_____ _____
Date Signature of Patient

_____ _____
Date Signature of parent, guardian or authorized representative

_____ _____
Date Witness

Faxed or Mailed By: _____

Date: _____

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CONSENT FOR TREATMENT OF A MINOR

We/I, the undersigned_____, parent(s) and/or guardian(s) of a

minor child_____, give you full and conditional authority to

proceed with a clinical evaluation and treatment as your judgment indicates.

The consent is given by me/us as parent(s) and /or guardian(s) of said child. We/I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child. It is clearly understood that you are hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that your duties are performed with standard care and responsibility to the best of your professional ability.

Signed this_____ day of_____, 20_____

_____
Mother or Guardian

_____
Father or Guardian

The above explained to: (circle all that apply) Mother / Father / Guardian

By_____ on the_____ day of_____, 20_____

_____
Witness

_____
Date

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